Complete Summary

GUIDELINE TITLE

Acute pain management.

BIBLIOGRAPHIC SOURCE(S)

Young D. Acute pain management. Iowa City (IA): University of Iowa Gerontological Nursing Interventions Research Center, Research Dissemination Core; 1999 Apr 6. 37 p. [86 references]

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Acute pain, defined as pain occurring from a time-limited illness, a recent event such as surgery, medical procedures, or trauma.

GUIDELINE CATEGORY

Evaluation
Management

CLINICAL SPECIALTY

Geriatrics

INTENDED USERS

Advanced Practice Nurses
Nurses

GUIDELINE OBJECTIVE(S)

To manage acute pain among elderly patients.

TARGET POPULATION

Elderly patients who are hospitalized for procedures and/or conditions that are associated with acute pain.

INTERVENTIONS AND PRACTICES CONSIDERED

1. Baseline pain assessment
2. Educating patient and family about pain management
3. Monitoring the acute pain experience
4. Pharmacologic management
5. Nonpharmacologic management
6. Assessing effectiveness of pain management

MAJOR OUTCOMES CONSIDERED

1. Pain intensity
2. Respiratory complications
3. Patient satisfaction

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The guideline authors searched MEDLINE and CINAHL for articles on pain/aged/elderly; hospitalized elderly. Hand-searches of reference lists/table of contents for journals/books not in electronic databases were performed. Lastly, author searches for individuals highly published in elder pain literature were conducted.

NUMBER OF SOURCE DOCUMENTS

Over 400 source documents were utilized.

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Subjective Review

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review
Review of Published Meta-Analyses

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not applicable

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

These guideline recommendations were reviewed by content experts.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Baseline Pain Assessment

The baseline pain assessment can be completed prior to a known painful event such as surgery or a diagnostic procedure to best help health care professionals manage the elder's pain in a proactive manner. The following activities comprise a baseline assessment.

1. While pain is the standard term used in the protocol, it is commonly recognized that many elderly individuals use other terms (e.g., 'ache,' 'discomfort'). Use of preferred terminology will enhance understanding and participation by patients in their pain management program (McCaffery & Beebe, 1989; Miller et al., 1996).
    - Investigate pain terminology typically used by the patient and use this term throughout the implementation of protocol (McCaffery & Beebe, 1989; Miller et al., 1996).

2. Provide opportunity for individualized patient/family and nurse interaction. Involve family in all aspects of assessment and planning for pain management (AHCPR, 1992, Ferrell et al., 1991). Assess patient/family's current knowledge of pain management strategies that may be implemented during hospitalization (AHCPR, 1992).
3. Using a standard mental status tool, such as the Mini Mental State or the Short Portable Mental Status Questionnaire assess the patient's cognitive ability. Also assess functional status using the Katz ADL Scale or an institutional measure of functional abilities remembering to include sensory assessment. Obtain family assistance as needed (McCaffery & Pasero, 1999; Sengstaken & King, 1993).
4. Complete a thorough assessment of patient pain levels with the assistance of the patient and/or the family, which includes the following: (A Pain Assessment Inventory is available in the full protocol):
    a. Assess patient and family attitudes and beliefs regarding: pain and analgesics, prior successes/failures with analgesics, expectations regarding pain and stress during hospitalization. Fear of addiction and analgesic side effects, beliefs related to ageism, passivity of patient role, and stoicism function as barriers to patient's report of pain (Ferrell et al., 1990; Hofland, 1992; Ward et al., 1993, 1998; Yates, Dewar, & Fentiman, 1995).
    b. Assess sociocultural variables (e.g., ethnicity; acculturation) which may influence pain behavior and expression (Koopman, Eisenthal, & Stoeckle, 1984; McDonald, 1994; Neill, 1993; Streltzer & Wade, 1981).
    c. Determine history of other chronic disorders which may also cause pain and interfere with accurate assessment of acute pain (AHCPR, 1992; Donovan, Dillon, & McGuire, 1987).
    d. Investigate medication use for chronic conditions that may interact or interfere with analgesic use (Hutchinson, 1986).
    e. Assess patient for depression and/or anxiety which may alter pain perception and enhance intensity of pain (Casten et al., 1995; Turk, Okifuji, & Scharff, 1995).
    f. Investigate methods commonly used by the patient to relieve pain (e.g., folk/home remedies) and methods used to cope with pain (e.g., distraction, prayer (Ferrell, 1995; McCaffery & Pasero, 1999).
    g. If the patient is noncommunicative, try to elicit from the family the patient's usual pain behaviors such as withdrawal, agitation, facial grimacing, guarding, moaning (Hurley et al., 1992; Prkachin, 1993).
    h. Assess pain intensity by selecting a tool based on the patient's preferences and cognitive/functional abilities. The Verbal Descriptor Scale, Pain Thermometer, Numeric Rating Scale and Faces Scale have an acceptable accuracy, are preferred by elderly persons and can often be used by individuals with cognitive impairment (K.A. Herr, personal communication, April 10, 1999; Herr & Mobily, 1993; Herr, Mobily, & Richardson, 1998).

        Examples of Pain Scales that have been used with elderly patients:

        - Verbal Descriptor Scale (VDS)
        - Pain Thermometer (PT)
        - Numeric Rating Scales (NRS)
        - Faces Pain Scale (ES)

Please note: Mildly to moderately cognitively impaired individuals are often able to rate pain using these instruments, however individual patient ability to do so should be assessed (Ferrell BA, Ferrell BR, & Rivera, 1995; Herr & Mobily, 1993; Herr, Mobily, & Richardson, 1998; Jensen, Karoly, & Braver, 1986; Kremer, Atkinson, & Ignelzi, 1981; Parmelee, Smith, & Katz, 1993; Porter et al., 1996).

Educate Patient and Family about Pain Management

Research has demonstrated that implementing an educational program for pain management for the patient and family helps promote effective pain management (Ferrell, Rhiner, & Ferrell, 1993). Although this program was developed for elders with cancer pain at home the overall structure of the program can also be adapted for elders with acute pain. The following activities can be included in this program.

1. General information about pain
    - Provide information regarding planned procedure and associated painful sensations to the patient and family prior to the upcoming procedure or surgery (AHCPR, 1992; Wachter-Shikora, 1983). Then offer opportunities for patient and family to discuss fears/concerns regarding the diagnostic procedure or surgery (Schmitt & Woolridge, 1973).
    - Provide patient and family with a brochure, such as the brochure offered through the Agency for Healthcare Research and Quality (AHRQ) (formerly the Agency for Health Care Policy and Research [AHCPR]) publication titled "Pain Control After Surgery: A Patient's Guide".
      This brochure (AHCPR Publication No. 92-0021) is available for sale from:

      AHRQ Publications Clearinghouse
      PO Box 8547
      Silver Spring, MD 20907-8547
      Call 800 358-9295 (in the US) or (410) 381-3150 (outside the US). Information is also available at the AHRQ Web site.

    - Explain to patient and family that pain can be managed and/or relieved (AHCPR, 1992; Yates, Dewar, & Fentiman, 1995) and the importance of reporting pain and pain control in the recovery process (e.g., facilitation of post-op exercises to prevent complications). Coach the patient in accurately reporting pain (AHCPR, 1992; Puntillo & Weiss, 1994; Ward & Gordon, 1994; Wilkie et al., 1995).
    - Explain to the patient and family the importance of preventing rather than 'chasing' pain in effective pain management (AHCPR, 1992; Ferrell et al., 1994).
2. Pain Assessment
    - Explain the pain assessment schedule and method of pain assessment utilizing selected assessment tool(s). Assess the patient's and family's understanding and accurate use of selected tool (AHCPR, 1992; Ferrell et al., 1994).

- Communicate with the patient and set an acceptable level of pain control (AHCPR, 1992) that is based on pain rating criteria.
- Explain the need to differentiate pain related to procedure and pain related to other chronic disorders (Ferrell, 1995).

3. Pharmacologic Management
    - Allay common fears/misconceptions regarding opiate use, such as addiction and respiratory depression (AHCPR, 1992; Ferrell et al., 1994).
    - Negotiate pain rating criterion for analgesic administration (i.e., a rating on pain assessment tool (AHCPR, 1992).
    - Explain common side effects of analgesics (e.g., constipation) and planned interventions for any side effects experienced (AHCPR, 1992).
    - Describe as well as demonstrate typical analgesic regimen (e.g., PCA) (AHCPR, 1992).
4. Nonpharmacologic Management
    - Describe cognitive/behavioral pain management options (e.g., relaxation strategies, imagery) and cutaneous stimulation options (heat/cold; Transcutaneous Electrical Nerve Stimulation [TENS]) and select options based on patient preference and cognitive/functional abilities (AHCPR, 1992; Mobily, 1994).
    - Explain/demonstrate routine post-procedure exercises/activities (e.g., coughing) and methods to decrease discomfort from these (e.g., splinting) (AHCPR, 1992).

<u>Monitoring The Acute Pain Experience</u>

1. Be aware that older individuals often suffer from chronic pain in addition to acute pain and implement strategies to relieve pain from chronic disorders as much as possible (AGS Panel on Chronic Pain in Older Persons, 1998; AHCPR, 1992).
2. Assess and document characteristics, intensity, duration, and effects of pain: Use selected assessment tool (AHCPR, 1992).
    - Assess pain at least every two hours and during rest, during activity, and through the nighttime when pain is often heightened (AHCPR, 1992; American Pain Society, 1995; Nelson et al., 1990). Ability to sleep does not indicate absence of pain (Donovan, Dillon, & McGuire, 1987).
    - Observe for nonverbal cues of pain (e.g., grimacing, guarding) and sleep disruption) (Baker et al., 1996; Duggleby & Lander, 1994; Hurley et al., 1992; McCaffery & Pasero, 1999; Miller et al., 1996; Prkachin, 1993; Simons & Malabar, 1995).
    - Elicit pain statements from communicative, cognitively impaired patients and use a selected assessment tool (Parmelee, Smith, & Katz, 1993; Sengstaken & King, 1993). Try several tools to evaluate which one is most easily used by the cognitively impaired individual. Many cognitively impaired subjects can complete at least one of the pain scales included in this protocol (Ferrell, Ferrell, & Rivera, 1995; Herr & Mobily, 1993).
    - In noncommunicative, cognitively impaired patients, observe for change in usual behavior (e.g., withdrawal, increased confusion, agitation), facial expressions of pain (e.g., grimacing), bodily tension, fidgeting, and vocalization (Feldt, Ryden, & Miles, 1998; Ferrell, Ferrell

& Rivera, 1995; Miller et al., 1996; Porter et al., 1996; Simons & Malabar, 1995). Research indicates that failure to assess and treat pain in these individuals is often due to an unfounded belief by healthcare providers that pain sensations are diminished in individuals with cognitive impairments (Cariaga et al., 1991; Hurley et al., 1992; Marzinski, 1991; Sengstaken & King, 1993).

- Assess for autonomic responses typically associated with acute pain (e.g., increased heart rate and blood pressure; increased or decreased respiratory rate; diaphoresis) (Eland, 1988; Kehlet, 1989).
- Assess pulmonary function (e.g., respiratory rate, lung sounds, signs of hypoxia) for pain-related complications every four to eight hours (AHCPR, 1992, Puntillo & Weiss, 1994).
- Differentiate procedural pain from pain due to chronic disorders or complications of procedure (e.g., new pain, increased intensity of pain, pain not relieved by previously effective strategies) (AHCPR, 1992).
- Assess the patient for atypical presentation of complications commonly seen in elderly. For example:
    - Shortness of breath and confusion with MI and absence of or delayed chest pain (Ambepitiya et al., 1994; Bayer et al., 1986).
    - Absence of pain during intra-abdominal emergencies (Bender, 1989).
    - Pain of various conditions often referred from the site of origin (Butler & Gastel, 1980).
- Document pain assessment findings on a flowsheet that includes: date, time, pain rating, use of analgesics, other pain intervention, vital signs and side effects.

<u>Pharmacological Management</u>

1. Use the following guidelines for analgesic administration:
    - Elderly patients receive significantly less analgesic medication than younger adults experiencing similar painful conditions/procedures, therefore leading to inadequate pain relief in these older patients. This tendency may be due to a belief on the part of healthcare providers that, in general, pain sensation decreases with age. There is no research base to support this misguided belief (Donovan, Dillon, & McGuire, 1987; McCaffery & Pasero, 1999).
    - Ethnic minorities receive significantly less narcotic analgesics for similar painful events secondary to ethnic influences on the part of the patient (e.g., reluctance to request medication) and/or the caregiver (e.g., misinterpretation of ethnic-based pain behavior). Formal caregivers must assess for ethnic influences in order to provide appropriate pharmacological interventions (McDonald, 1994).
    - Cognitively impaired elderly individuals receive significantly less analgesics then cognitively intact elders with similar painful events. There is no empirical evidence to support that cognitive impairment is associated with decreased pain sensation (Bell, 1997; Horgas & Tsai, 1998).
    - Safe analgesic administration in the elderly is complicated by interactions with multiple chronic disorders, multiple drugs to treat these disorders, nutritional alterations (e.g., protein deficiency) and

altered pharmacokinetics (Hutchinson et al., 1986; Lamy, 1983; Nolan et al., 1988). The incidence of acute confusion and other adverse reactions increases with the number of prescription drugs administered (AHCPR, 1992; Hutchinson et al., 1986).

- Elderly individuals generally receive greater peak and longer duration of action from analgesics than younger individuals (Bellville et al., 1971; Koh & Thomas, 1994), thus dosing should be initiated at lower doses (1/4-1/2 adult dose) and titrated carefully (AGS Panel on Chronic Pain Older Persons, 1998).
- Use patient-controlled analgesia for intravenous analgesics particularly during immediate post-procedure period (e.g., 48 hours), but monitor and titrate cautiously due to increased potential for toxicity (Egbert et al., 1990; Lamy, 1983).
- Recognize that cognitively impaired patients may require nurse assisted use of PCA (AHCPR, 1992).
- Administer oral analgesics on an around-the-clock (ATC) basis (American Pain Society, 1999). Administer on PRN basis later in course as indicated by patient's pain status. If given on PRN basis, administer 30 minutes prior to activities (e.g., PT) and postoperative exercises (AGS Panel on Chronic Pain in Older Persons, 1998). Assess for breakthrough pain and need for supplemental doses (AGS Panel on Chronic Pain in Older Persons, 1998; AHCPR, 1992).
- If acute confusion develops, assess for other contributing factors prior to altering the prescription or discontinuing analgesic use. Confusion in postoperative patients has been found to be associated with unrelieved pain rather than opiate use (Duggleby & Lander, 1994; Hurley et al., 1992).
- Assess bowel function daily and initiate patient's home protocol or the Constipation Management research-based protocol to prevent the constipating effects of analgesic use. Assess for signs of ileus related to narcotic analgesics (AHCPR, 1992; Nimmo et al., 1975).
- Measure intake and output and assess for signs of urinary retention/suppression (AHCPR, 1992).
- Slowed intramuscular absorption of analgesics in elderly patients may result in delayed/prolonged effect of IM injections, altered analgesic serum levels and possible toxicity with repeated injections. This is more common with IM meperidine than IM morphine. Use IV or intraspinal analgesia for rapid control of severe pain (Conner & Deane, 1995; Pasero & McCaffery, 1996).
- Antiemetics for analgesic-induced nausea may result in problems in elderly patients due to anticholinergic effects (bowel and bladder dysfunction, confusion, movement disorders) (AHCPR, 1992; Ferrell, 1995).

2. The following analgesics and adjuvants may produce increased confusion levels in elderly patients:
    - NSAIDS (greatest risk during initial use) (Goodwin & Regan, 1982; Roth, 1989; Rozzini et al., 1996).
    - Meperidine (Kaiko et al., 1983).
    - Pentazocine (Talwin) (Ferrell, 1995).
    - Anticholinergics (Antihistamines, e.g., hydroxyzine; Phenothiazines) (Ferrell, 1995).
3. Drug interactions occur more frequently in the elderly (Doucet et al., 1996).

4. The analgesic effects of NSAIDS supplement the analgesic effects of prescribed opioids, therefore reducing the dose of opioid that is required for effective pain management. Thus, they may reduce the incidence of opioid-induced respiratory depression in elderly patients. The following NSAID complications are common among elderly patients and must be carefully monitored:
    - GI bleeding especially with initiation of drug or higher doses of a drug (Griffin et al., 1991). Therefore, avoid use, if patient has a history of peptic ulcers (Roth, 1989). A meta-analysis of the variability and risk of GI complications of NSAIDS found that low dose ibuprofen (under 1,600 mg/day) was associated with the lowest relative risk (Henry et al., 1996). Initiate antacid regimen and administer with food. Monitor for signs of GI bleeding.
    - Nephrotoxicity (Perneger et al., 1994). Avoid use if patient has a history of renal impairment, congestive heart failure, concurrent volume depletion or diuretic use.
    - Bleeding disorders (Roche & Forman, 1994; Roth, 1989). Avoid use if patient has a history of bleeding disorders or a concurrent use of anticoagulants, or use platelet-sparing agent (e.g., Salsalte, Diflunisal)(AHCPR, 1992).
    - Confusion (Roth, 1989; Goodwin & Regan, 1982). Monitor patient for new onset or increased confusion in demented patients during initial use. Long-term use has been found to have a protective effect on cognitive decline (Rozzini et al., 1996).
    - Other (e.g., constipation, headaches, dizziness) (Rozzini et al., 1996).
5. Age-associated physiologic changes (e.g., reduced renal and/or liver function) result in increased toxicity with aspirin use (Baskin & Goldfarb, 1983).
6. ACETAMINOPHEN is an effective analgesic in the elderly and does not produce the gastric and bleeding complications seen with NSAIDS. Other complications that may be associated with acetaminophen usage include:
    - Increased risk of end-stage renal disease with long-term use (Perneger, Whelton, & Klag, 1994).
    - Toxicity due to reduced hepatic metabolism (McCaffery & Beebe, 1989).
    - Over coagulation with warfarin in the outpatient setting (Hylek et al., 1998).
7. OPIATES produce greater analgesic effect and have a higher serum peak and duration in elderly patients (Bellville et al., 1971; Kaiko, 1980). Therefore:
    - Initiate opioid therapy with 25% to 50% lower dose than that recommended for adults and slowly increase dosage by 25% on an individual basis, balancing analgesic need with undesirable effects (AHCPR, 1992; American Pain Society, 1999; Nimmo et al., 1975). Use intravenous, intraspinal or oral routes of administration, not intramuscular (McCaffery & Pasero, 1999).
    - Monitor for respiratory depression (e.g., less than 10/min) and reduced arterial oxygen saturation (less than 85%) particularly in opioid-naive patients. Cheynestokes during sleep without other adverse signs <u>does not</u> necessitate opioid reduction (AHCPR, 1992).
    - Omit if respiratory complications develop or if patient experiences excess sedation. Administer naloxone (Narcan) (AHCPR, 1992).
    - Monitor for other side effects of opioids including sedation, hypotension, urinary retention (especially if coexisting BPH),

constipation/ileus, and exacerbation of Parkinson's disease (AHCPR, 1992; Ferrell, 1995; Nimmo et al., 1975).

- MEPERIDINE should be avoided in elderly patients due to the possibility of normeperidine toxicity, especially if the patient has coexisting CHF or renal impairment. Normeperidine produces CNS excitability with tremors, seizures, mood alterations and confusion. Symptoms are managed with anticonvulsants. Narcan should NOT be administered for normeperidine toxicity (AHCPR, 1992; Kaiko et al., 1982; McCaffery & Pasero, 1999; Szeto et al., 1977).

  Avoid intramuscular use of meperidine because of tissue irritation and muscle fibrosis, compounding reduced tissue mass in elderly patients (AHCPR, 1992). Intramuscular meperidine is poorly absorbed and leads to variable analgesic response and may result in increased dosage requirements and associated side effects (Austin, Stapleton, & Mather, 1980; Connor & Deane, 1995).

- MORPHINE SULFATE is a safer choice than meperidine in the elderly for the following reasons:
  - Longer duration of action, therefore less overall dosage is required and less possibility of toxicity (Connor & Deane, 1995; McKenzie, Rudy, & Ponter-Hammill, 1992; McDonald, 1993).
  - Reduced hemodynamic alterations (Lee et al., 1976).
  - Effects are most understood and predictable (Ferrell, 1995).
- TRANSDERM FENTANYL is NOT indicated in management of acute pain (Ferrell & McCaffery, 1997). It has been used in elders with chronic pain but should be used with caution in opioid-naive elderly due to extreme potency and potential for delirium and respiratory depression (Ferrell, 1995; Wakefield et al., 1998).
- COMBINED AGONISTS/ANTAGONISTS have properties that may be pronounced in elderly patients:
  - § Butorphanol (Stadol) and pentazocine (Talwin) produce psychotomimetic effects and may lead to confusion (AHCPR, 1992).
  - § Buprenorphine (Buprenex) is less likely to produce respiratory depression, but this complication cannot be completely reversed with naloxone (Narcan) (McCaffery & Beebe, 1989).
- OPIOIDS WITH LONG HALF-LIFE (i.e. methadone, levorphanol) may result in toxicity in elderly patients (McCaffery & Beebe, 1989).
- Identify other medications prescribed for chronic conditions that may potentiate opioid side effects (sedation with sedatives, tranquilizers, antiemetics; postural hypotension with antihypertensives, tricyclics; confusion with phenothiazines, tricyclics, antihistamines and other anticholinergics) (Freund, 1987; Koh & Thomas, 1994; Reidenberg, 1982).

Nonpharmacological Management

- Assist patient to enhance his/her sense of personal control over pain (e.g., allow movement at preferred pace) (Bensink et al., 1992; Nelson et al., 1990).

- Demonstrate interest in patient's comfort level and willingness to implement/alter strategies as needed to facilitate pain relief; frequently reinforce availability of pain relief measures; encourage verbalization regarding pain concerns (AHCPR, 1992; Fraser & Kerr, 1993; Nelson et al., 1990; Wilder-Smith & Schuler, 1992).
- Support usual pain coping methods (e.g., prayer, meditation) (Ferrell, 1995).
- Facilitate use of home/folk pain remedies, unless contraindicated (McCaffery & Beebe, 1989).
- Use relaxation strategies and distraction (e.g., breathing, massage, touch, music, imagery) to complement analgesics. Avoid imagery in-patients with severe cognitive impairment or psychoses (AHCPR, 1992; Bensink et al., 1992; Ceccio, 1984; Dossey, 1995; Fraser & Kerr, 1993; Good, 1995; Heitz, Symreng, & Scamman, 1992; Mobily, 1994; Swinford, 1987; Weinrich & Weinrich, 1990; Wells, 1982).
- TENS has been used successfully in elderly for postoperative pain (Hargreaves & Lander, 1989; Neary, 1981).
- The elderly can benefit from multimodal pain treatment that includes pharmacologic and non pharmacologic interventions (Herr & Mobily, 1997).

Assessing Effectiveness of Pain Management

For each individual patient:

1. Assess pain relief from interventions (30 minutes after parenteral, 60 minutes after oral) using patient-based feedback through one of the pain intensity scales described herein (AHCPR, 1992; American Pain Society, 1999).
2. Document all pharmacologic and nonpharmacologic pain interventions on a pain flowsheet (Document pain assessment findings on a flowsheet that includes: date, time, pain rating, use of analgesics, other pain intervention, vital signs and side effects. A pain flowsheet is included in the full protocol) (AHCPR, 1992; McCaffery & Pasero, 1999).
3. Monitor each patient's pain flowsheet for patterns, in order to identify the efficacy of the pain intervention activities chosen and to determine any need for revision in the pain plan (AHCPR, 1992; McCaffery & Pasero, 1999).

   The Pain Level Outcome from the Nursing Outcomes Classification (NOC) can also be used to assess the effectiveness of pain management for each individual patient (Johnson & Maas, 1997, p.226).

4. If pain management is not adequate, revise the plan based on consultation among the patient's physician, nursing staff, and the pharmacy department.
5. In collaboration with the patient and his/her family, develop a discharge plan for pain management and provide written instructions, which include drug dosage, interval, drug interactions, and prevention of common side effects (e.g., constipation). Review routine medications for possible interactions. Assess patient and family member's ability to obtain analgesics and intervene accordingly (AHCPR, 1992).

For quality improvement of nursing care:

Acute pain management for elderly patients should be evaluated at the organizational level (unit, hospital, nursing home, etc.) to evaluate whether the

staff is using the pain management guidelines in a consistent and effective manner. Therefore it is important to monitor the use of the pain management guidelines in a structured manner. The form, Pain Management Implementation Monitor, can be used for this purpose.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

References open in a new window

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

Not specifically stated for each recommendation

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Effective acute pain management, resulting in the alleviation of pain or a reduction in pain to a level of comfort that is acceptable to the patient

Subgroups Most Likely to Benefit:

- Patients who are 65 years of age or older
- Patients who are hospitalized for operative/diagnostic procedures or other medical disorders associated with acute pain

POTENTIAL HARMS

- Confusion in the elderly with use of analgesics and adjuvants
- Drug interactions
- Opioid-induced respiratory depression
- Nephrotoxicity and GI bleeding with use of NSAIDS
- Toxicity due to reduced hepatic metabolism with use of acetaminophen

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

This research-based practice protocol is a general guideline. Patient care continues to require individualization based on patient needs and requests.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Not applicable

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Young D. Acute pain management. Iowa City (IA): University of Iowa Gerontological Nursing Interventions Research Center, Research Dissemination Core; 1999 Apr 6. 37 p. [86 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1997 (revised 1999 Apr 6)

GUIDELINE DEVELOPER(S)

University of Iowa Gerontological Nursing Interventions Research Center, Research Dissemination Core - Academic Institution

SOURCE(S) OF FUNDING

National Institute of Nursing Research, NIH (Grant #P30 NR03979).

GUIDELINE COMMITTEE

University of Iowa Gerontological Nursing Interventions Research Center Research Development and Dissemination Core

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Author: Diane Young, MSN, RN. Series Editor: Marita G. Titler, PhD, RN, FAAN.

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline. It is an update of a previously issued guideline (Acute pain management. Iowa City (IA): University of Iowa; 1997. 37 p. [Research-based protocol; no. 1997]).

An update is not in progress at this time.

GUIDELINE AVAILABILITY

Electronic copies: Not available at this time.

Print copies: Available from the University of Iowa Gerontological Nursing Interventions Research Center, Research Dissemination Core, 4118 Westlawn, Iowa City, IA 52242. For more information, please see the University of Iowa Gerontological Nursing Interventions Research Center Web site.

AVAILABILITY OF COMPANION DOCUMENTS

None available

NGC STATUS

The original summary was completed by ECRI on October 1, 1998. The information was verified by the guideline developer on December 15, 1998. An updated summary, based on the 1999 revision of the original guideline document was completed by ECRI on May 1, 1999. The updated information was verified by the guideline developer on June 23, 1999.

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